

## 6. Working-age incapacity and disability benefits

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### Key findings

**Incapacity and disability benefits make up a large share of total working-age welfare spending.**

Just over half of disabled working-age people who are not in paid work receive disability or incapacity benefits. The government will spend £24 billion on these benefits for 3.5 million working-age people in 2016–17. This is 26% of non-pensioner benefit spending.

**There has been a big shift from spending on incapacity benefits to spending on disability benefits over time.**

Spending on incapacity benefits is now a smaller share of national income than in any year since 1989–90. In part, that reflects the fact that average awards have fallen from 24% of average earnings in 1986–87 to 19% in 2016–17. Meanwhile, spending on disability benefits for working-age people has consistently grown as a share of national income.

**The government has committed to halve the ‘disability employment gap’.**

17% of people of working age are disabled. 49% of them are in paid work, compared with 81% of the non-disabled. This suggests that the government ultimately wants around one-third of working-age disabled people who are not working to be in work.

The employment gap narrowed over the 2000s and has since been stable. Looking at those aged 25 and over, the gap is especially large among the low-educated: 42% versus 85%.

**Incapacity benefit claims are increasingly concentrated among the low-educated, and less concentrated among older men, than in the past.**

Low-educated men aged 25–34 are now twice as likely to receive incapacity benefits as high-educated men aged 55–64. This will present a significant challenge: closing the employment gap, and reducing the incapacity benefits caseload, will depend on increasing the labour market attachment of an increasingly low-skilled group.

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**There is considerable variation across Great Britain in the proportion of working-age individuals receiving incapacity benefits.**

This proportion varies from 2.2% in the City of London to 13.0% in Blackpool. The proportion of working-age individuals in the ESA support group also varies dramatically.

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**Recent governments have struggled to achieve what they intended with reforms to incapacity and disability benefits.**

In 2012, spending on incapacity benefits was forecast to be 27% lower in 2015–16 than in 2010–11; but instead it was 6% higher. So spending was £15 billion, not £10 billion as forecast. There is a need to avoid over-optimism about what further reform can achieve.

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**The government has proposed that Jobcentre work coaches have more discretion to engage the ESA support group in work-related activity in a way tailored to individual circumstances.**

This is the group assessed as having limited capability for work-related activity, which has unexpectedly become the majority of incapacity benefits claimants. To deliver a substantial impact will certainly require considerably greater resources. The support group is 50% bigger than the group of ESA and JSA claimants (combined) who are already engaged in work-related activity.

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**Increased discretion could have positive consequences (e.g. engagement tailored to individual circumstances) or negative consequences (e.g. inconsistency in treatment of similar claimants).**

The support group is a diverse group with a range of circumstances, and many of them have multiple health conditions. A particular challenge when potentially engaging them in more work-related activity will be treating those with mental and behavioural disorders appropriately. These disorders are now the primary health condition in half of ESA cases.

## 6.1 Introduction

Close to three-quarters of those aged 16–64 are in paid work. Driven in particular by strong growth in female employment over the last half a century, this is the highest overall employment rate seen in the UK since at least 1971. However, unsurprisingly, employment rates vary across different groups, not least between the non-disabled and the disabled. The Equality Act 2010 defines a disabled person as someone who has a physical or mental impairment that has a ‘substantial’ and ‘long-term’ negative effect on their ability to do normal daily activities.<sup>1</sup> According to the Labour Force Survey (LFS), 17% of working-age individuals are disabled on this definition, with 81% of non-disabled working-age individuals in employment compared with just 49% of disabled people.<sup>2</sup> The government has highlighted, expressed concern, and committed to halve, this 32 percentage point disability employment gap. This goal is the focus of the recent publication *Improving Lives: The Work, Health and Disability Green Paper* produced jointly by the Department for Work and Pensions (DWP) and the Department of Health (DH).<sup>3</sup>

One aspect considered in the Green Paper, and the subject of this chapter, is the role of incapacity and disability benefits. Incapacity benefits – such as employment and support allowance (ESA) – are designed to provide financial support to those who cannot secure an income from employment due to disability or ill health. Disability benefits – such as personal independence payment (PIP) – are designed to compensate for increased costs of living incurred as a result of having a disability or poor health. Box 6.1 provides some more details of these benefits. The LFS suggests that of those working-age individuals who are out of work and disabled, just over half (53%) receive either incapacity benefits or disability benefits or both (16% receive incapacity benefits only, 18% receive disability benefits only and a further 19% receive both). This does mean that around 47% of those who are out of work and disabled (on this definition) receive neither benefit, so it is important to recognise that the benefits system is only a part of what the government should be thinking about.<sup>4</sup> But it is a significant part and, as we shall see, it is an area of spending that has proven difficult to control and to predict, and a policy area that has been challenging in the sense that reforms have not always had the intended consequences.

In 2016–17, the government is forecast to spend £24.4 billion on disability and incapacity benefits for working-age people. This amounts to:

- 26% of non-pensioner benefit spending;
- £14.8 billion of spending on incapacity benefits and £9.5 billion on disability benefits;
- incapacity benefits payments to 2.5 million, or 6%, of working-age individuals in Great Britain, at an average rate of £116 per week;
- disability benefits payments to 2.1 million, or 5%, of working-age individuals, at an average rate of £88 per week;<sup>5</sup>

<sup>1</sup> See <https://www.gov.uk/definition-of-disability-under-equality-act-2010>.

<sup>2</sup> Individuals aged 16–59 (women) or 16–64 (men) in LFS 2015Q4 to 2016Q3.

<sup>3</sup> Published in October 2016. See <https://www.gov.uk/government/consultations/work-health-and-disability-improving-lives>. Hereafter referred to as ‘the Green Paper’.

<sup>4</sup> Average over out-of-work disabled individuals aged 16–59 (women) or 16–64 (men) in LFS 2015Q4 to 2016Q3.

<sup>5</sup> DWP caseload for 2016–17.

- 3.5 million, or 9% of the working-age population, receive at least one of these benefits, with 1.3 million working-age individuals receiving both types of benefits;<sup>6</sup>
- £2.4 billion (17% of incapacity benefits spending) of spending on those in the ESA WRA group, £11 billion (74% of incapacity benefits spending) on those in the ESA support group (with the remaining £1.3 billion or 9% going on those still in the assessment phase or on other incapacity benefits such as IB and SDA).

### Box 6.1. Incapacity and disability benefits<sup>a</sup>

The current incapacity benefit for which new claimants are considered is employment and support allowance, which has replaced incapacity benefit (IB) and severe disablement allowance (SDA). In the vast majority of cases, ESA claimants must undergo a work capability assessment (WCA) to establish the potential for them to return to work. Exceptions to this include, for example, those with a terminal illness. The WCA determines whether the claimant can carry out a range of activities, both physical and cognitive. A points-based system is used to determine whether the claimant has met the eligibility threshold. Following the WCA, those deemed eligible for ESA are placed either in the work-related activity (WRA) group – in which case they have to attend regular meetings with a Jobcentre work coach aimed at helping them to return to work – or the support group – in which case the individual is eligible for a more generous rate of ESA and there is no conditionality (although they can volunteer for job support if they wish, but very few do).

ESA claimants in either group can also get disability premiums. Eligibility for these is dependent on also receiving certain rates of disability benefits (see below), except that those in the support group are automatically entitled to the ‘enhanced disability’ premium (currently £15.75 per week). Some small amounts of ‘permitted work’ can be done by ESA claimants without affecting ESA entitlement (see Section 6.3 for further details). Including premiums, the average incapacity benefits award is currently £116 per week.

For those of working age, the primary disability benefits are disability living allowance (DLA) and its replacement, personal independence payment. PIP recipients may receive either or both of a ‘daily living’ component, paid if the individual needs assistance with any of a range of activities such as eating and washing, and a ‘mobility’ component, paid if the individual needs help to move around. Both may be paid at either a standard or an enhanced rate. The average disability benefits award for those of working age is currently £88 per week.

<sup>a</sup> For full details of how the incapacity and disability benefits systems work and of the rates, see A. Hood and A. Norris Keiller, ‘A survey of the UK benefit system’, IFS Briefing Note BN13, 2016, <https://www.ifs.org.uk/publications/1718>.

<sup>6</sup> See page 53 of Department for Work and Pensions and Department of Health, ‘Technical annex to Improving Lives: the Work, Health and Disability Green Paper’, October 2016, <https://www.gov.uk/government/statistics/work-health-and-disability-green-paper-data-pack>. Hereafter referred to as ‘the Green Paper Technical Annex’.

Clearly, these benefits are significant, both in fiscal terms and as a source of income for a large number of people. Indeed, there are claimants who have little or no other income. For example, a single claimant without children who is not on DLA/PIP may, after rent, have only their £73.10 (if in the ESA WRA group) or £125.55 (if in the ESA support group) of ESA per week. Central issues for policymakers include whether sufficient financial support is being provided to the right individuals, whether such support is conditional on an appropriate degree of work search or work-related activity, and whether claimants (including those with evolving or fluctuating health conditions) are getting an appropriate level, and type, of engagement from Jobcentres.

The government has stated that the Green Paper is not seeking to make further cuts to the generosity of the social security system but instead is focused on attempting to reduce the disability employment gap. This is in contrast to reforms announced since 2010: the Office for Budget Responsibility (OBR) estimates that these will have the effect of cutting spending on incapacity and disability benefits in 2020–21 by a total of £4.6 billion, relative to the counterfactual of no reforms being announced (comprising £2.5 billion from incapacity benefits and £2.1 billion from disability benefits, noting that some of this will affect those over the state pension age).<sup>7</sup> Note that actual spending is forecast to increase in real terms by £4.5 billion, from £21.3 billion to £25.8 billion (in 2016–17 prices), over the decade from 2010–11.

These reforms have been far from uncontroversial. Of course this is a difficult area of policy. But symptoms of problems are widespread. First, the WCA and (until March 2015) its administration by Atos has been subject to much criticism, not least by the National Audit Office.<sup>8</sup> Second, 8% of those deemed to be fit for work by the WCA over the period from October 2013 to March 2016 (35,000 individuals) went to an appeal tribunal, and in 57% of cases the appeal was upheld.<sup>9</sup> This is arguably suggestive of a system that is not working well. Third, as we describe in Section 6.2, recent reforms have not reduced spending by as much as intended. Fourth, in response to this failure to cut spending as intended, in the March 2016 Budget the government announced it would implement a reform to remove eligibility for PIP from those deemed to have the lowest-cost disabilities in order to reduce spending in 2019–20 by £1.3 billion. The then Secretary of State for Work and Pensions, Iain Duncan Smith, resigned and the Government backtracked on the policy two days after the Budget.

### Trends in working-age disability and employment

Over the past 15 years, recorded rates of disability amongst those of working age have increased. The rate of disability among women aged 25–59 and men aged 25–64 rose from 15.9% in the year up to 2001Q1, to 18.5% in the year up to 2003Q2, and then to 19.5% in the year up to 2016Q3.<sup>10</sup> This has been driven in part by higher reported rates of mental

<sup>7</sup> See chart 5 on page 11, of the Office for Budget Responsibility, *Welfare Trends Report: October 2016*, [http://budgetresponsibility.org.uk/docs/dlm\\_uploads/Welfare-Trends-Report.pdf](http://budgetresponsibility.org.uk/docs/dlm_uploads/Welfare-Trends-Report.pdf).

<sup>8</sup> See National Audit Office, *Contracted-Out Health and Disability Assessments*, January 2016, <https://www.nao.org.uk/report/contracted-out-health-and-disability-assessments/>.

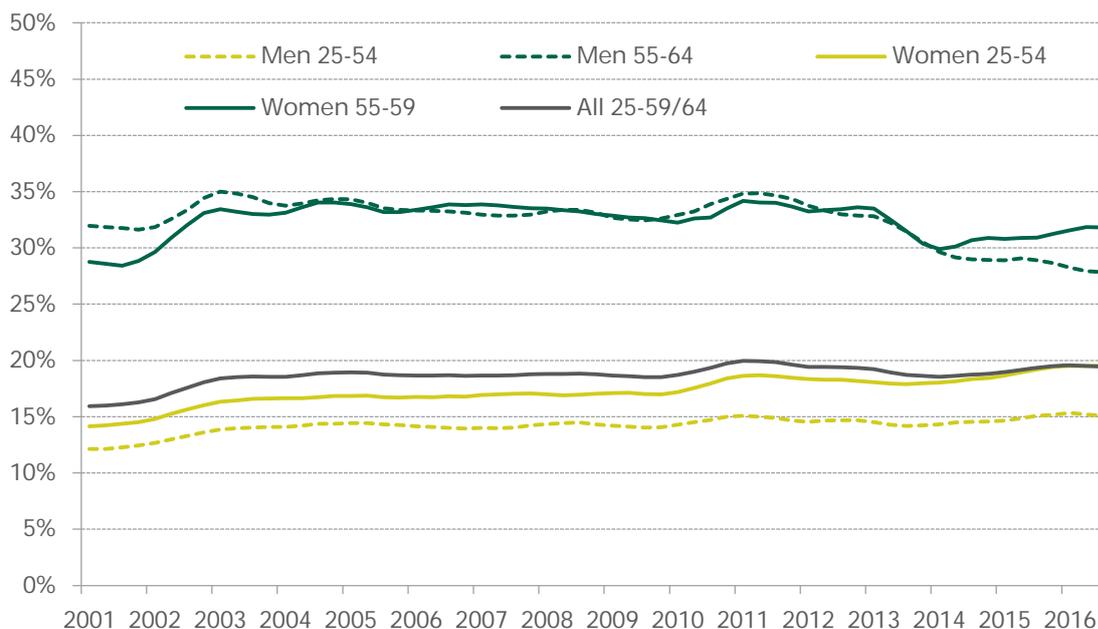
<sup>9</sup> See Department for Work and Pensions, 'ESA: outcomes of work capability assessments including mandatory reconsiderations and appeals', December 2016, <https://www.gov.uk/government/statistics/esa-outcomes-of-work-capability-assessments-including-mandatory-reconsiderations-and-appeals-december-2016>.

<sup>10</sup> Here we use data from the LFS designed to capture disability according to the Disability Discrimination Act 1995 definition. We do this as data based on the Equalities Act 2010 definition are not available for earlier years.

illness among young people. The extent to which this reflects changes in awareness of, and willingness to seek help for, mental health problems, as opposed to increased prevalence of mental health issues, is unclear.<sup>11</sup> Figure 6.1 shows the four-quarterly rolling average of the disability rate across this period, for different age groups, split by sex. Rates of disability are, unsurprisingly, higher for older individuals than for younger individuals. At younger ages, disability is both more prevalent and growing at a faster rate among women than among men. Looking at those closer to the state pension age, the disability rates of men and women had remained close to each other for the decade from 2004 to 2013. Since then, the disability rate of older males has continued to fall, while that of older women has risen slightly, such that older women are now significantly more likely to be disabled than their male counterparts.

As the government has highlighted, the employment rate of disabled individuals is significantly lower than that of non-disabled individuals. Figure 6.2 shows that this ‘disability employment gap’ fell over the decade from 2001 to 2010 but has not fallen significantly since then. This is true in aggregate and across age groups and sexes. The latest data show that the gap is currently smallest among younger women, and slightly larger among older men than among older women or younger men.

**Figure 6.1. Rates of disability by age and sex (2001 to 2016)**

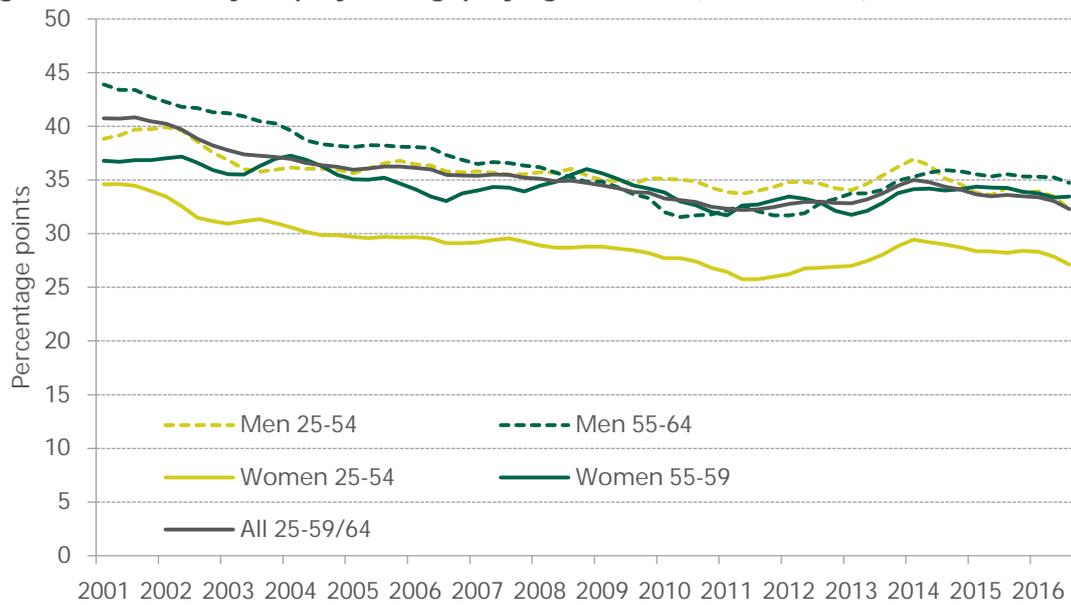


Note: Figure shows four-quarterly moving average of rates of disability. Disability is defined using a series of questions designed to measure the Disability Discrimination Act 1995 definition of disability. While the Equalities Act 2010 supersedes the DDA 1995, LFS data only consistently attempt to measure the latter and trends are comparable.

Source: Authors’ calculations using data from the Labour Force Survey.

<sup>11</sup> See *Adult Psychiatric Morbidity Survey 2014*, NatCen Social Research and the Department of Health Sciences, University of Leicester, 2016, <http://content.digital.nhs.uk/catalogue/PUB21748/apms-2014-full-rpt.pdf>.

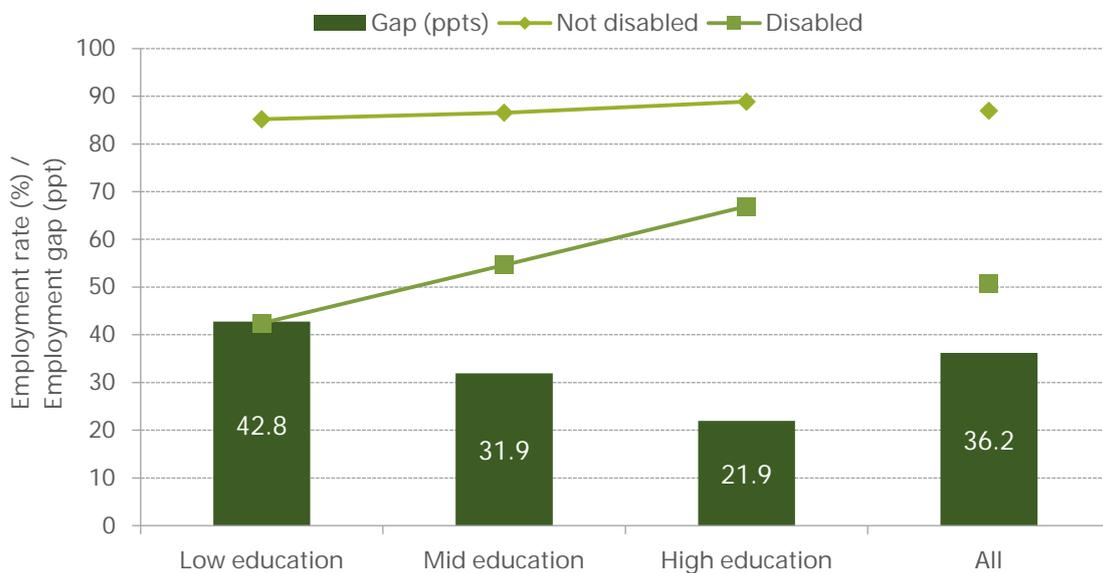
Figure 6.2. Disability employment gap by age and sex (2001 to 2016)



Note: Disability employment gap is the difference between the employment rate of those reporting as disabled and those reporting as not disabled. Figure shows four-quarterly moving average of rates of the disability employment gap.

Source: Authors' calculations using data from the Labour Force Survey.

Figure 6.3. Employment rate, by Equalities Act 2010 status and education, and resulting disability employment rate gap



Note: Data from 2015Q4 to 2016Q3 inclusive.

Source: Authors' calculations using data from the Labour Force Survey.

The disability employment gap also varies significantly across education groups, as illustrated in Figure 6.3.<sup>12</sup> While non-disabled individuals who are highly educated are only slightly more likely to be employed than those with lower levels of education, more highly educated disabled individuals have an employment rate that is over 20 percentage points higher than that of low-educated disabled individuals. This matters not least because 54% of disabled individuals have a low level of education (having left school at the compulsory attendance age, or before), compared with just 36% of the non-disabled population. Whereas one-in-nine of those with high education (having left school after age 18) have a disability, this is true of one-in-four of those with low education. Therefore it looks as if any serious reduction in the disability employment gap is likely to require a significant increase in employment among disabled individuals with relatively low levels of education. Overall, the numbers in Figure 6.3 imply that halving the disability employment gap – as the government intends – would involve cutting the proportion of working-age disabled people who are not in paid work by around one-third (assuming that the target is not met through reductions in employment rates among the non-disabled).

This chapter focuses on the design of the support provided by incapacity benefits and disability benefits which, as already mentioned, are received in some combination by just over half of out-of-work disabled individuals of working age. Section 6.2 looks at some of the broad trends in spending and benefit receipt. Section 6.3 discusses the principles and current practice in the design of incapacity and disability benefits and how this will change as universal credit (UC) is rolled out. Section 6.4 provides more detail on the characteristics of those receiving incapacity benefits and sets them in the context of the Green Paper proposals and the goal to halve the disability employment gap. Section 6.5 concludes.

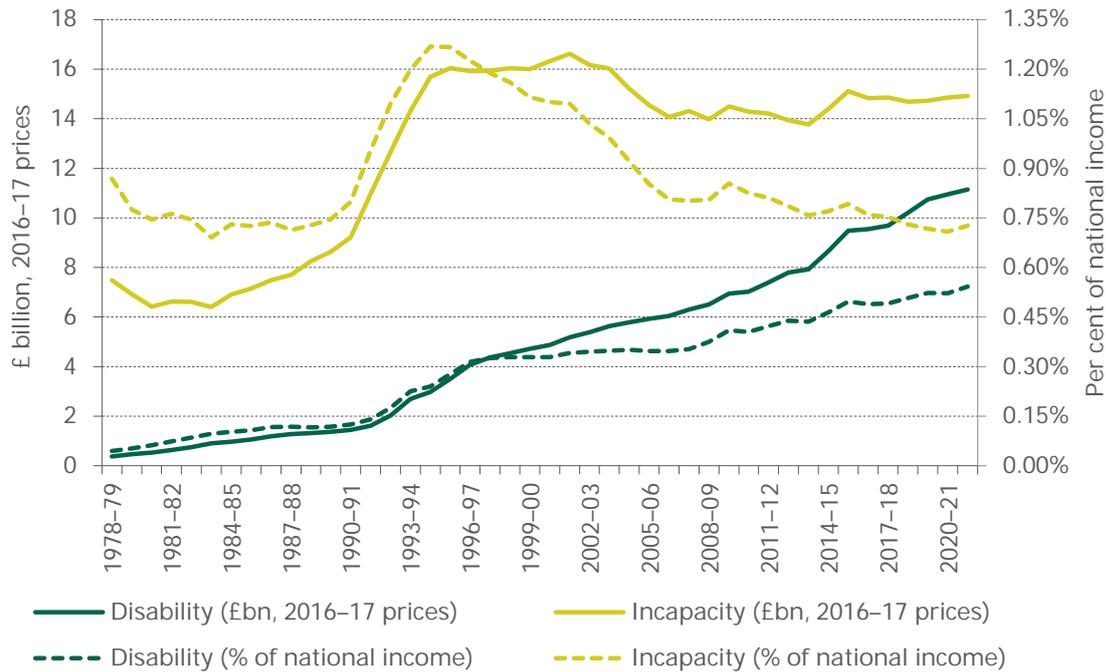
## 6.2 Patterns of spending on incapacity and disability benefits

In broad terms, we have witnessed a big shift in the mix of spending since the mid 1990s, away from incapacity benefits and towards disability benefits. Spending on working-age incapacity benefits as a percentage of national income is currently at its lowest level since 1989–90 and is forecast to reach its lowest level for over 40 years by the end of this parliament. In real terms, it has changed little in the past decade, is lower than it was 20 years ago, and is forecast to rise by less than 1% in real terms over the next years. By contrast, working-age disability benefits spending has been growing both in real terms and as a percentage of national income. Over the next five years, it is forecast to continue growing in real terms, but to stabilise as a share of national income. These long-run trends in spending on incapacity and disability benefits for those of working-age are shown in Figure 6.4. In 1994–95, spending on incapacity benefits was 5.3 times that on disability benefits for those of working age. This multiple has now fallen to 1.6 and is forecast to continue falling such that by 2021–22 it will be 1.3.<sup>13</sup>

<sup>12</sup> Note that here we use the information in the LFS data which captures the Equalities Act 2010 definition of disability.

<sup>13</sup> One interruption to the recent trends outlined above is the sharp growth in spending on both types of benefits between 2013–14 and 2015–16. In part this was caused by the rate of inflation falling after benefit rates were set, which pushes up average awards in real terms. These two years also saw falling inflation as measured by the Consumer Prices Index (CPI), which, because benefits are typically updated each April with reference to the rate of inflation observed in the previous September, means that benefit levels are higher in real terms when deflated by out-turn CPI. The converse occurs when inflation rises. There was also a sharp

**Figure 6.4. Spending on working-age incapacity and disability benefits in Great Britain (1978–79 to 2021–22)**



Note: 'Incapacity benefits' include ESA, IB, SDA, invalidity benefit, sickness benefit, and income support on grounds of disability. 'Disability benefits' include DLA, PIP, attendance allowance and mobility allowance.

Source: Authors' calculations using DWP expenditure and caseload tables 2016.

Much of the rapid rise in incapacity benefits spending in the late 1980s and early 1990s was accounted for by the doubling in caseload over this period, from 1.3 million in 1986–87 to 2.6 million in 1996–97.<sup>14</sup> This increase did not result from any explicit reform to the system. But it did eventually trigger a significant reform in April 1995 to try to bring the caseload down, when IB replaced invalidity benefit. The unemployment rate – which in the UK ran at above 5.8% for the whole of the 1980s and 1990s – has been shown to be one determinant of reduced off-flows from these benefits in this period.<sup>15</sup>

Since 2003–04, there has been a gradual decline in the incapacity benefits caseload, to 2.5 million in 2016–17. Meanwhile, average real weekly spending on incapacity benefits per claimant is £116 in 2016–17, compared with £111 per person in 1986–87 (in 2016–17 prices). This is the net result of a rise in the average weekly award to £126 by 1996–97, followed by a fall to £106 by 2010–11, and subsequent rises over the last parliament (as a large – and larger-than-expected – number of ESA claimants moved into the support

increase in the disability benefits caseload and average generosity of payment, coinciding with the roll-out of PIP. This was partly driven by the fact that a greater share of claimants were awarded the higher rate of the daily living component than were awarded the higher rate under DLA (Office for Budget Responsibility, *Welfare Trends Report: October 2016*, [http://budgetresponsibility.org.uk/docs/dlm\\_uploads/Welfare-Trends-Report.pdf](http://budgetresponsibility.org.uk/docs/dlm_uploads/Welfare-Trends-Report.pdf)).

<sup>14</sup> For a discussion of these trends see, for example, M. Anyadike-Danes and D. McVicar, 'Has the boom in incapacity benefit claimant numbers passed its peak?', *Fiscal Studies*, 2008, 29, 415–34, <http://www.ifs.org.uk/publications/4471>.

<sup>15</sup> See R. Disney, and S. Webb, 'Why are there so many long term sick in Britain?', *Economic Journal*, 1991, 101, 252–62.

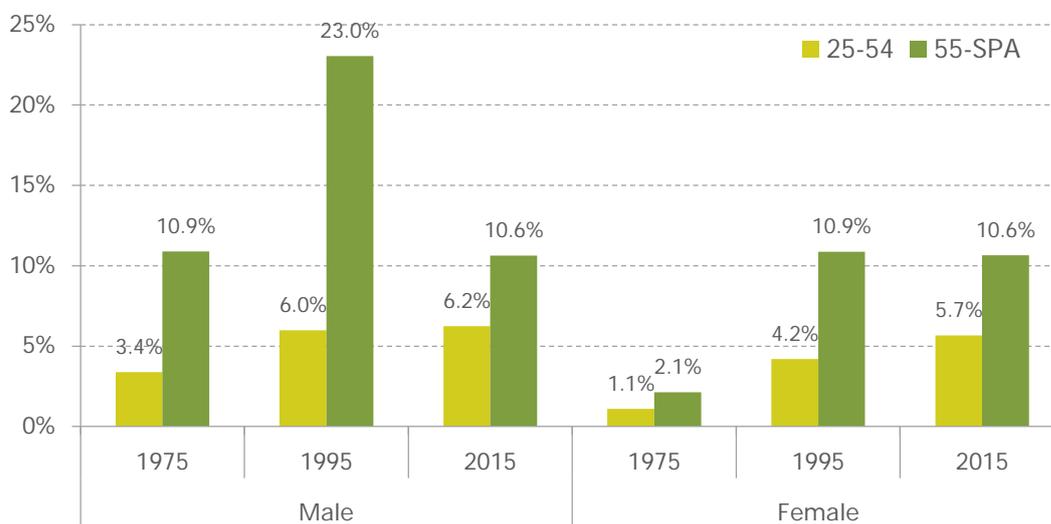
group rather than the WRA group, as discussed later around Figure 6.9). It is worth noting that we are comparing amounts over time after adjusting for CPI inflation, but until 2011 these benefits were typically increased in line with RPI inflation (which is now thought to overstate true inflation) – hence historical changes in awards look more generous in real terms now than they did at the time. As a share of male full-time average earnings, the average award has fallen from 24% in 1986–87 to 19% in 2016–17.

The disability benefits caseload has grown fairly steadily since the introduction of DLA in the early 1990s. Along with a moderate increase in the average real generosity of disability payments, this has driven the consistent rise in disability spending.

Figure 6.5 illustrates the change in incapacity benefits claimant rates for men and women at both younger and older ages. This shows some stark patterns. A large portion of the rise of the incapacity benefits claimant rate between 1975 and 1995 was amongst older men, and this has been almost completely reversed since then. Claimant rates of women have been catching up with those of men (at least in part due to higher employment rates for women meaning that they are subsequently more likely to be able to qualify for contributory incapacity benefits), and have been growing particularly strongly for those aged 25 to 54. As a result, while claim rates are still higher among older individuals than among younger individuals, this is true to a much lesser extent than in the past.

Using the Labour Force Survey rather than administrative data, we can also examine the way that trends in claimant rates vary by levels of education. Figure 6.6 updates previous work by IFS researchers<sup>16</sup> and shows a striking decrease in rates of incapacity benefits

**Figure 6.5. Recipient rates for incapacity benefits in 1975, 1995 and 2015 (for age 25 to 54 and 55 to state pension age (SPA), by sex)**

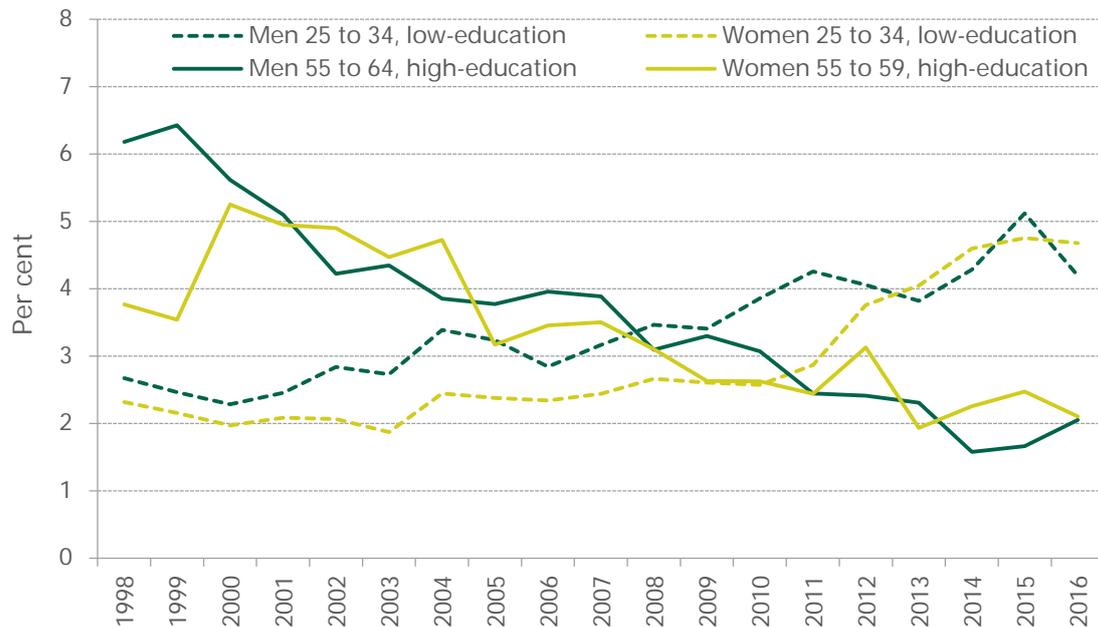


Note: ‘Incapacity benefits’ are here defined as IB and ESA.

Source: Authors’ calculations using data from the DWP benefit caseload tabulation tool, Economic Research Institute of Northern Ireland and ONS population estimates and projections.

<sup>16</sup> See J. Banks, R. Blundell and C. Emmerson, ‘Disability benefit receipt and reform: reconciling trends in the United Kingdom’, *Journal of Economic Perspectives*, 2015, 29(2), 173–90.

**Figure 6.6. Recipient rates for incapacity benefits among selected age, sex and education groups over time (1998 to 2016)**



Note: Data run from 1998Q2 to 2016Q3. ‘Low education’ corresponds to leaving education at or before the compulsory school-leaving age, while ‘high education’ corresponds to leaving education after age 18. The middle-educated group (and middle age groups) are excluded from the figure.

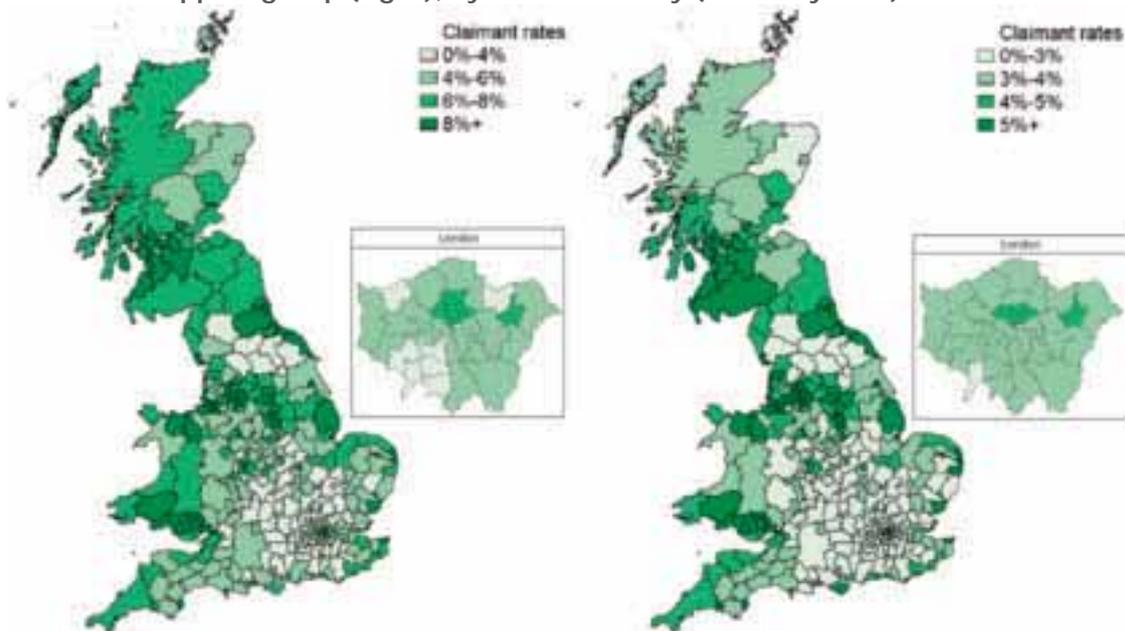
Source: Authors’ calculations using data from the Labour Force Survey.

receipt among those who are older and more highly educated, from just over 5% in the early 2000s to around 2% in 2016. Meanwhile, claimant rates among the young and low-educated have approximately doubled. The likelihood of claiming incapacity benefits is now much better predicted by education level, and much less well predicted by age, than used to be the case. It is likely that the declining association with age is related to an increasing prevalence of mental health problems relative to physical health problems (see Section 6.4). But whatever the cause, the result is striking: in 1998, men aged 55–64 with high education were 2.3 times more likely to be in receipt of incapacity benefits than men aged 25–34 with low education; but by 2016, the younger low-education group of men were twice as likely to be receiving incapacity benefits as the older high-education group.

Incapacity and disability benefits policy matters considerably more in some parts of the country than others. Figure 6.7, reproduced from work by the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University,<sup>17</sup> shows that incapacity benefits claimant rates among those of working age vary from 2.2% in the City of London to 13.0% in Blackpool. More broadly, in certain parts of the country – the South West of Scotland, South Wales, the North East of England and Merseyside – claimant rates consistently exceed 8%, whereas in much of the South of England the claimant rate is below 4% (left-hand map). The map on the right shows that a similar geographic pattern

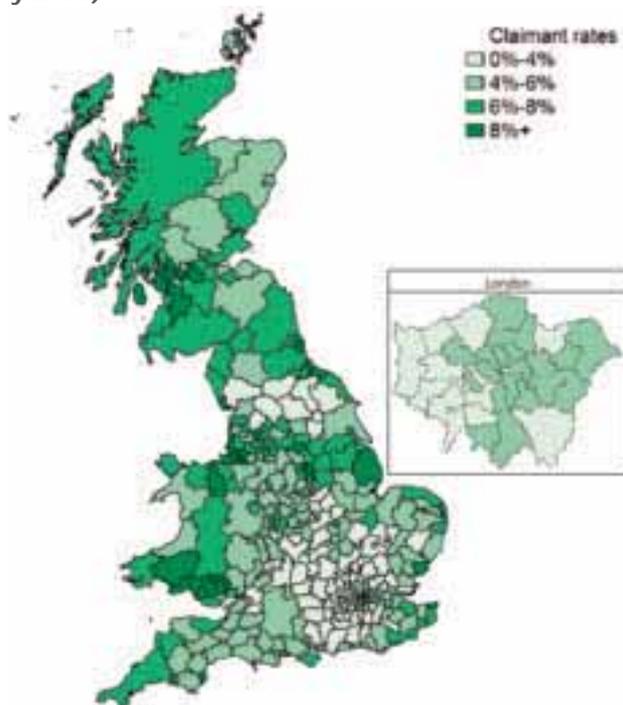
<sup>17</sup> C. Beatty and S. Fothergill, *Jobs, Welfare and Austerity: How the Destruction of Industrial Britain Casts a Shadow over Present-Day Public Finances*, CRESR, Sheffield Hallam University, 2016, <http://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/cresr30th-jobs-welfare-austerity.pdf> (using DWP and ONS data).

**Figure 6.7. Percentage of 16- to 64-year-olds claiming any incapacity benefits (left) and in ESA support group (right), by local authority (February 2016)**



Source: The left-hand map is reproduced from C. Beatty and S. Fothergill, *Jobs, Welfare and Austerity: How the Destruction of Industrial Britain Casts a Shadow over Present-Day Public Finances*, CRESR, Sheffield Hallam University, 2016, <http://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/cresr30th-jobs-welfare-austerity.pdf> (with the permission of the authors). The right-hand map uses data from the Green Paper Technical Annex.

**Figure 6.8. Percentage of 16- to 64-year-olds claiming disability benefits, by local authority (February 2016)**



Source: Reproduced from C. Beatty and S. Fothergill, *Jobs, Welfare and Austerity: How the Destruction of Industrial Britain Casts a Shadow over Present-Day Public Finances*, CRESR, Sheffield Hallam University, 2016, <http://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/cresr30th-jobs-welfare-austerity.pdf> (with the permission of the authors).

holds if we look specifically at those claimants in the ESA support group, who will – due to the government’s Green Paper – be the subject of much of the discussion in Section 6.4. Figure 6.8, again reproduced from work by CRESR, shows that disability benefits claims among those of working age are concentrated in similar parts of the country.

### Recent out-turns relative to forecasts

Over the last parliament, spending on both disability and incapacity benefits consistently exceeded forecasts. In the case of incapacity benefits, this was driven largely by the failure of the caseload to fall as expected. At Autumn Statement 2012, the OBR assumed that, as the roll-out of the replacement of IB with ESA continued, the incapacity benefits caseload would fall by 21% by 2015–16 compared with its level at the start of the parliament.<sup>18</sup> This assumption turned out to be very inaccurate: the caseload actually only fell by 4% over this period. Combined with a 10% increase in average awards (compared with a forecast decline of 8%), this resulted in a total rise in real spending of 6% over the last parliament, compared with the Autumn 2012 forecast fall in spending of 27%. This forecast error in average award for incapacity benefits recipients is partially explained by many more claimants being placed into the support group than was expected. At Autumn Statement 2012, the OBR forecast that by 2015–16, the ESA support group would be one-quarter of the size of the WRA group. In reality, the support group was 3.4 times as large as the WRA group that year, meaning that a much higher proportion of recipients were entitled to the support group premium.

The stubbornness in the incapacity benefits caseload comes in the context of a longer-term failure to meet aspirations to reduce the number of claimants. In 2005, the then Labour government set a target to have 1 million fewer incapacity benefits claimants in 2015 than in 2005, in part as a result of replacing IB with ESA. We now know that the claimant count fell by less than 300,000 over that decade.

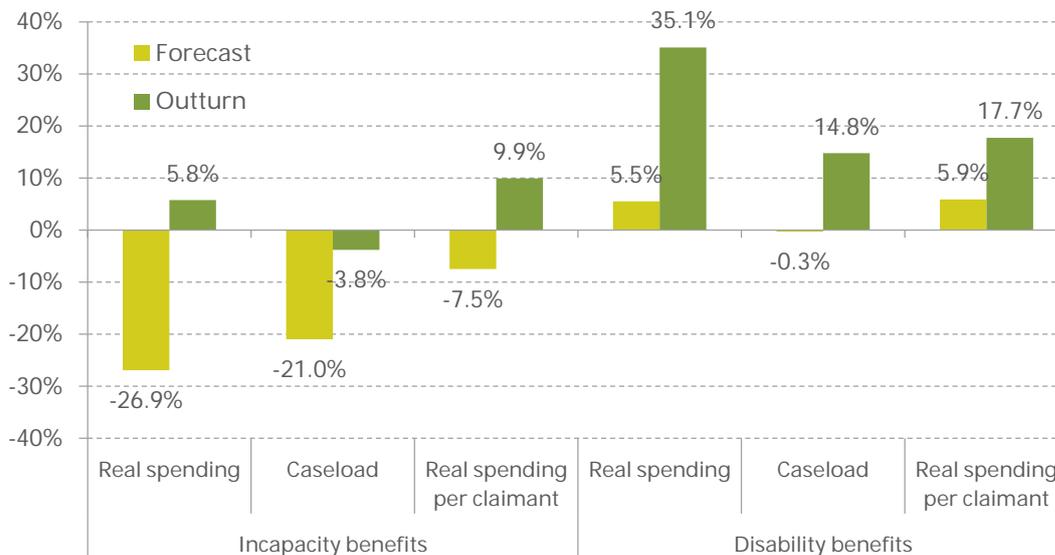
On disability benefits, the Autumn 2012 forecast was for the caseload to fall marginally as DLA began to be replaced by PIP, and for both average spending per claimant and total real spending to increase by 6% over the five years from 2010–11 to 2015–16. In reality, the caseload and average spend per claimant increased by 15% and 18% respectively, leaving real-terms disability spending 35% higher in 2015–16 than in 2010–11. The higher average generosity than forecast was due in part to a greater share of claimants being awarded the higher rate of PIP than had been the case under DLA. These discrepancies between forecasts and out-turns are summarised in Figure 6.9.

In its own analysis of these patterns in the most recent *Welfare Trends Report*, the OBR states that ‘the major structural reforms to the incapacity and disability benefits systems have proceeded more slowly than expected and have saved less than initially predicted’ and that ‘the pattern of revisions to our forecasts for incapacity and disability benefits and to the rollout of universal credit highlight how the impact of these sorts of structural reforms is particularly hard to forecast and prone to optimism bias’.<sup>19</sup> Avoiding such

<sup>18</sup> We use the Autumn 2012 OBR forecast as our baseline for comparison as this was the point at which the government announced the 1% uprating of the assessment phase and WRA component of ESA. Since this point, policy on the rates of disability and incapacity benefits has not changed, so forecasts can be sensibly compared with out-turns.

<sup>19</sup> Office for Budget Responsibility, *Welfare Trends Report: October 2016*, [http://budgetresponsibility.org.uk/docs/dlm\\_uploads/Welfare-Trends-Report.pdf](http://budgetresponsibility.org.uk/docs/dlm_uploads/Welfare-Trends-Report.pdf).

**Figure 6.9. Autumn Statement 2012 forecasts for working-age incapacity and disability benefits spending growth from 2010–11 to 2015–16, compared with the latest out-turn**



Note: ‘Incapacity benefits’ is the DWP definition (includes IB, ESA and SDA for those of working age). ‘Disability benefits’ is the DWP definition (includes DLA and PIP for those of working age).

Source: HM Treasury, *Autumn Statement 2012*; DWP expenditure and caseload tables 2016; authors’ calculations.

optimism bias, and forming plans of sufficient detail to be reasonably confident that they can deliver roughly what is intended, will be one key challenge for the government when implementing whatever reforms follow the Green Paper.

### 6.3 The structure of financial support: principles and practice

As outlined in the introduction, there are two main routes through which ill health or disability can have detrimental impacts on the finances of those affected. First, it can directly add to the cost of living by creating needs that have to be paid for (e.g. a mobility scooter). This is recognised in the welfare system through *disability benefits*: in particular DLA and PIP, for those of working age. Second, ill health can limit one’s ability to secure income from paid work. *Incapacity benefits* are the benefit system’s response to this: in particular ESA, and its counterparts in UC, which is replacing income-related ESA as it is rolled out. Although many health conditions fall into both of the above categories, the overlap is far from perfect: for example, there are people whose disability leads to substantial extra costs of living but who can still earn a decent income from paid work. Hence this may justify the benefits system having two distinct tools to address these two consequences of ill health. Of course, in addition to those tools, the state also provides substantial support to working-age individuals in ill health through the NHS and social care; this is analysed in Chapter 5.

What about how the level of financial support is structured? For disability benefits, one might argue that the answer should be very simple: these benefits are there to cover (some of) the direct costs of disability, and a mobility scooter (for example) costs the same

regardless of income, so the level of support for disability should be invariant to income. This would imply that there should be no form of means-testing (or taxation) of disability benefits. On the other hand, one might argue that higher-income people are better placed to bear the risk of disability themselves (e.g. by saving) or that extra costs simply have less impact on their welfare than an equivalent extra cost for someone on a lower income. In these cases, one might want some element of means-testing or taxation of disability benefits.

How are our disability benefits actually designed? On the face of it, they are neither means-tested nor taxable: given the outcome of a health assessment, the support given through disability benefits is the same regardless of how much income or assets the person has. In practice, however, receipt of disability benefits can entitle claimants of out-of-work benefits to disability premiums. Although these premiums show up as spending on those out-of-work benefits, for the most part they are effectively targeted additional disability benefits focused specifically on the very poorest (in the case of income-related ESA), plus a smaller group of people with some history of paid work whose ability to work is now limited by health but whose family may have other income (in the case of contributory ESA).<sup>20</sup> Hence the additional support provided in light of the extra costs of disability is in effect somewhat means-tested (but, unlike a typical means-tested benefit, people of all income levels can get some support for the costs of disability).

For incapacity benefits that support people whose ability to work is limited by ill health, one approach would be a scheme to compensate for (some portion of) the earnings that those people miss out on. Economically, there is a potential rationale for this because insurance against ill health is the kind of good in which a private market may fail to operate well. The US system of Social Security Disability Insurance is a scheme of this kind. In the UK, though, there is little or no relationship between previous earnings and the level of incapacity benefits entitlement. Contributions-based ESA is available if earnings in the previous two tax years were above a certain level, but beyond that there is no relationship between previous earnings and the level of entitlement (and for the WRA group it is now available for only one year). Meanwhile, income-based ESA, which 80% of ESA recipients are claiming, provides an income floor irrespective of prior earnings. Hence our incapacity benefits are better understood as a part of the welfare safety net than as an earnings-replacement scheme.

ESA currently provides a higher safety net for out-of-work individuals than the safety net provided to people on out-of-work benefits for reasons other than ill health (i.e. people on jobseeker's allowance (JSA) or income support). From April 2017, this will no longer be true for new ESA-WRA recipients, for whom ESA will be cut from £102 to £73 per week so that it is aligned with the JSA rate. To give a sense of scale of the long-run impact of this change, the ESA-WRA currently comprises about 450,000 people, or a fifth of all ESA recipients. The ESA support group, however, who account for two-thirds of ESA recipients, will continue to receive about £52 per week more than JSA recipients: comprising the support group

<sup>20</sup> As of May 2016, 20% of ESA claimants were claiming contributions-based ESA and not income-related ESA. Some of these would qualify for income-based ESA, and hence could have claimed ESA even if they had not met the contribution conditions. Source: DWP tabulation tool ([http://tabulation-tool.dwp.gov.uk/100pc/esa/tabtool\\_esa.html](http://tabulation-tool.dwp.gov.uk/100pc/esa/tabtool_esa.html)).

element itself, at £37 per week, and an enhanced disability premium of £16 that the group are automatically entitled to.<sup>21</sup>

Given that we have separate disability benefits that recipients of ESA can claim, the fact that a substantial portion of ESA claimants face direct costs of disability not faced by JSA recipients is not in itself a coherent argument for having ESA rates higher than JSA rates. If one believed that DLA/PIP do not adequately cover the costs of disability, the appropriate response could be to increase the level of those benefits. The think tank *Reform* has advocated a package whereby ESA rates are reduced to be in line with JSA rates, and the proceeds used to increase PIP and to increase efforts to move JSA claimants into paid work.<sup>22</sup>

If the government decided to abolish the support group element of ESA, this would take £37 per week away from 1.5 million recipients, reducing annual spending by £2.9 billion in 2017–18. In addition, if the support group were no longer automatically passported to the enhanced disability premium, some portion of them (i.e. those who could not qualify for the premium via other means – primarily DLA/PIP receipt) would lose a further £16 per week.<sup>23</sup> That would be enough to pay for a significant increase in disability benefit rates for the 2.1 million working-age recipients of disability benefits. Of course, a substantial fraction of those who lost from the first reform would be at least partly compensated by the second. There would also be lots of net winners on disability benefits but not in the support group of ESA (which would include pensioners if their rates of disability benefits were also increased). But the group of individuals in the ESA support group who did not receive disability benefits would lose a substantial proportion of their income. Under universal credit, the equivalent of the support group element is substantially larger (see below), so in the long run the gross takeaways and gross giveaways possible from this kind of reform package would be larger too.

There are arguments one could make, however, in support of a differential between JSA and ESA rates, and therefore against a reform in the direction set out above. One potential economic argument relates to efficiency and incentives. People in ill health may be less likely to work regardless of the financial incentives they face. If that is the case, higher out-of-work benefits for this group incur less of a cost on the economy, in terms of reduced labour supply, than higher JSA. This argument may be especially true of the ESA support group. But serious analysis of the incentive costs would be needed before any of this could be confidently asserted.<sup>24</sup> Another argument could be that we want to target

<sup>21</sup> The amounts in pounds per week here are under the April 2017 system. Those in the ESA WRA group can be entitled to the enhanced disability premium too, but only if they receive the highest rate of either the care component of DLA or the daily living component of PIP (discussed below) or the armed forces independence payment. Claimant numbers are for May 2016 and are from the DWP's tabulation tool ([http://tabulation-tool.dwp.gov.uk/100pc/esa/tabtool\\_esa.html](http://tabulation-tool.dwp.gov.uk/100pc/esa/tabtool_esa.html)). About 13% of ESA recipients are in neither the ESA WRA group nor the ESA support group, because they are still in the 'assessment phase' waiting for the extent of their incapacity to be assessed. The rate for those in the assessment phase is the same as the JSA rate.

<sup>22</sup> C. Pickles, E. Holmes, H. Titley and B. Dobson, *Working Welfare: A Radically New Approach to Sickness and Disability Benefits*, Reform, February 2016, <http://www.reform.uk/publication/working-welfare-a-radically-new-approach-to-sickness-and-disability-benefits/>.

<sup>23</sup> Of course, one could also simply get rid of all the disability premiums in out-of-work benefits. As discussed above though, this raises a slightly different set of issues. It is in large part a decision about whether or not to effectively means-test disability benefits, rather than a decision about whether incapacity benefits should be more generous than other out-of-work benefits.

<sup>24</sup> There is empirical research on some of these kinds of incentive effects in other countries. One recent paper looked at the impacts of the Disability Insurance (DI) scheme in the US, weighing up the incentive costs of DI

resources at people who have a low income for a prolonged period and/or low lifetime incomes, and being in ill health could be a proxy for this. Finally, one could imagine philosophical (rather than economic) arguments, such as the idea that people prevented from working due to ill health tend to be more ‘deserving’ than people who are not employed for other reasons.

The government is implicitly making judgements about the merits of these kinds of arguments in setting and changing JSA and ESA rates. It would therefore be helpful for the government to set out its thinking and rationales more explicitly – not least because this would help to highlight what more evidence is needed to make better decisions (e.g. evidence on responsiveness to financial incentives or the persistence of low-income spells for those in ill health).

### Universal credit

Income-related ESA is one of six means-tested benefits for working-age families that will be integrated into one under universal credit (alongside income-based JSA, income support, housing benefit, child tax credit and working tax credit). The introduction of UC will have two particular implications for the way that financial support for incapacity is structured, which we briefly discuss below.

First, a notable feature of the current system is that, although we have distinct incapacity and disability benefits, there are actually interactions between them. In particular, ESA claimants can qualify for ‘premiums’ (extra ESA) that are dependent on claiming the standard or enhanced rates of the daily living component of PIP (or the middle or higher rates of the care component of DLA). But when income-related ESA is rolled into UC, those premiums will be abolished, while the equivalent of the support group component of ESA will be increased.<sup>25</sup> As a result, support group ESA claimants who are on the relevant rates of DLA or PIP will lose £42 per week, while those in the support group who are not in receipt of DLA or PIP will gain £21 per week.<sup>26</sup>

As discussed earlier, these premiums are effectively an element of means-testing in our disability benefits system: if one is deemed to have ill health that leads to additional costs, the disability benefits system will provide extra support regardless of income level; but there is effectively an additional top-up of disability benefits, via the premiums, for those on ESA. Under UC, the government is therefore effectively moving to a purely non-means-tested disability benefits system (by abolishing the disability premiums), whilst increasing the generosity of incapacity benefits for those whose potential to work is deemed most limited by their health (by increasing the equivalent of the support group component of ESA). As discussed above, there are potential pros and cons of both of these decisions, so the government’s approach is not obviously unreasonable – though again it would be

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against the value of the insurance against ill health that it provides. The research concluded that reductions in DI from its current level would reduce social welfare overall because the reduced value of the insurance would outweigh the improvement in efficiency (i.e. the lowering of the incentive to claim DI rather than work). See H. Low and L. Pistaferri, ‘Disability Insurance and the dynamics of the incentive insurance trade-off’, *American Economic Review*, 2015, 105, 2986–3029. But all this is far removed from the policy context in the UK.

<sup>25</sup> Under UC, this will be called the ‘limited capability for work-related activity’ component.

<sup>26</sup> Those in the WRA group will lose £62 per week if they are on the middle rate of the care component of DLA or the standard daily living component of PIP, or £78 per week if they are on the enhanced care component of DLA or daily living component of PIP.

helpful for it to set out its arguments systematically with reference to the kinds of principles discussed above. Note that the overall shift that this effectively entails, away from disability benefits and towards incapacity benefits, is the opposite of the general trend over the past 25 years (see Section 6.2).

Second, the other change that UC will bring about concerns the relationship between benefit entitlement and paid work for those receiving incapacity benefits. On the one hand, this may not seem like the biggest issue relating to the structure of the benefits system. A DWP response to a Freedom of Information (FOI) request suggests that no more than around 2% of ESA claimants take up the option to do the very small amounts of paid work that are currently allowed under 'permitted work' rules (see below).<sup>27</sup> Nevertheless, given the government's own emphasis on increasing employment among disabled people from its current level, the financial incentives for such people to do this are clearly of relevance (and perhaps increasing relevance) for policy. For those on incapacity benefits, one relevant issue here is how the system deals with people whose health and ability to work improve and who can therefore potentially move into significant paid employment.

Under the 'legacy' system that UC will replace, the financial incentives of ESA claimants to do small amounts of paid work are strong, but their financial incentives to go beyond that can be very weak. This is because, under 'permitted work' rules, small amounts of earnings have no impact on benefit entitlement for these claimants;<sup>28</sup> but going beyond a certain limit has a mechanical 'cliff-edge' impact whereby all ESA is removed, and some housing benefit (HB) will often be lost in the process (since ESA acts as a passport to maximum HB).<sup>29</sup> The details differ according to circumstances but, taking someone earning the national living wage, the general pattern is that if they are either in the support group (the majority of ESA claimants) or on HB, then they will have less money if they do 16 hours of work per week than if they worked slightly less. For example for a single person with no children who was in the WRA group and on housing benefit, the loss from moving from just below to just above 16 hours of work per week would be £67 per week.<sup>30</sup>

Under UC, the equivalent to being placed in the WRA group is to be assessed as having 'limited capability for work' (LCW) and the equivalent to being placed in the support group is to be assessed as having 'limited capability for work-related activity' (LCWRA). For someone already assessed as LCW/LCWRA, unlike the legacy system there is no mechanical cliff-edge in support when earnings increase beyond a certain level.<sup>31</sup> This is potentially an important difference. However, it is plausible that a claimant's observed working behaviour would be one of the influences behind a decision over whether

<sup>27</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/553580/foi-48-2011-permitted-work.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/553580/foi-48-2011-permitted-work.pdf).

<sup>28</sup> Specifically, they can earn up to the equivalent of 16 hours per week at the national living wage under these rules (£120 per week in 2017–18). For the WRA group, this limit currently only applies for one year, after which a much lower earnings limit would apply. But from April 2017, the one-year restriction will be removed.

<sup>29</sup> The same will often be true of council tax support, though these schemes are now designed by local authorities, who have made varying choices. As a result, we ignore council tax support in what follows.

<sup>30</sup> This accounts for the fact that working tax credit entitlement (including disabled worker's element) would kick in at the same 16-hours point for a disabled worker.

<sup>31</sup> For people making a new UC claim, the 'permitted work' earnings limits inherited from the ESA system do still apply: you cannot be newly granted LCW or LCWRA status if earning more than that limit.

someone with LCW or LCWRA status should have their health reassessed (for the approximately half of these claimants not on DLA/PIP, which will act to protect LCW/LCWRA status under UC<sup>32</sup>). If claimants perceive this possibility, there may still be a significant incentive issue for those not on DLA/PIP and deciding how much paid work to undertake. Like under the legacy system, having LCW/LCWRA status can make a substantial difference to the amount of support you are entitled to. For someone doing paid work, a higher work allowance means that having LCW status can be worth up to £28 per week (or £58 per week if not claiming support for housing costs); and having LCWRA status confers an additional £73, via the equivalent of the support group premium under UC.<sup>33</sup>

Hence, UC will effectively give DWP decision-makers responsibility for managing delicate trade-offs between giving claimants the right financial incentives and fairly assessing health status as it evolves. This is potentially a better approach than the legacy system, which simply has *mechanical* cliff-edges in support: trade-offs can be managed in a way that is tailored to the circumstances of each claimant, including their evolving health. But it is also a complicated task to get right, and the outcomes of this process should be closely monitored. There may be a case for considering ‘intermediate’ rates of support that could be given to claimants in paid work who have recently lost LCW/LCWRA status, or guaranteeing the additional LCW/LCWRA-based entitlement for some limited period after being passed fit for work, to make the transition somewhat less severe.

#### 6.4 Incapacity benefit reform and the disability employment gap

The government has stated that it is committed to halving the employment gap between the disabled and the non-disabled. This is a significant challenge. The Green Paper consults on a wide range of issues around disability and employment, such as the role of employers, wider societal and attitudinal changes, cooperation between different relevant parts of the public sector, including the NHS, and the design of ESA. This section focuses on the group in receipt of incapacity benefits – and therefore predominantly not in paid work – and presents some new evidence on their characteristics in order to shed light on the potential challenges involved in getting these individuals into employment.

With regards to the design of ESA, the Green Paper proposes breaking the link that exists under the current system between the level of financial support and the kind of interaction that claimants have with their Jobcentre (and specifically their ‘work coaches’). Currently, while those placed in the ESA support group can choose to engage in work-related activities with a work coach at Jobcentre Plus, the level of financial support they get is not dependent on them doing so (whereas those in the ESA WRA group can be sanctioned for not doing so). To date, very few in the support group have volunteered for these activities. The Green Paper proposes that the decision on the level of financial

<sup>32</sup> Note that this passporting of LCW/LCWRA status from DLA/PIP receipt means that there is effectively still an element of means-testing of disability benefits under UC, in the sense that those on disability benefits can get additional UC (which is means-tested). The government might argue that this is more an administratively convenient way of passporting some ill people to LCW/LCWRA status without subjecting them to another health test, rather than a principled decision to effectively means-test disability benefits.

<sup>33</sup> There is an LCWRA element within UC of £73 per week, and both LCW and LCWRA status result in an enhanced work allowance (to an extent that depends on whether or not support for housing costs is also being claimed).

support given to an ESA claimant be made separately from decisions about the nature of the work-related activity the claimant would be expected to do.

This would mean that work coaches have discretion over the extent and manner of a claimant's engagement with the support group, allowing them to tailor it to the (potentially evolving) health conditions and disabilities of each individual. The success of such a change would depend in large part upon the abilities of work coaches to understand and engage successfully with the challenges faced by incapacity benefits claimants due to their health conditions and to use any greater discretion effectively.

This would also raise the possibility of those in the support group facing the risk of – and in some cases receiving – sanctions for not sufficiently engaging. Presently among ESA recipients, only those in the WRA group can be sanctioned (with 13,026 recipients sanctioned over the 12 months to June 2016).<sup>34</sup> The Green Paper suggests the possibility of keep-in-touch discussions between those in the support group and work coaches, which would presumably occur on a regular basis, that could be 'a voluntary or mandatory requirement'. If the greater engagement that the government wishes to see is to be achieved, then it will need to consider whether a compulsory approach would work best or whether there might be other ways of boosting engagement without the threat of a benefit sanction. For example, the government could trial a move to presuming that those in the ESA support group should participate in such activities – but allow them to opt out if they wish. This would be analogous to private pensions policy where, rather than compelling employees to save in a private pension – or leaving it up to them to choose to do so – the government is insisting that they are enrolled into a plan automatically but then allows them to leave the plan if they wish.

It is important to remember that, contrary to the original intention, the support group comprises the majority of ESA recipients (1.5 million of the 2.4 million recipients, as of May 2016). This matters first because it means that changes to the requirements placed on these claimants, and/or the interaction they have with Jobcentres, clearly have the potential to have significant impacts – for better or for worse – on a lot of people. It also means that the additional demands on time and resources within Jobcentres are also likely to be significant and they will need to be if any useful change is to be brought about. The support group is 50% larger than the group of ESA-WRA claimants and JSA claimants who are already engaged in work-related activity.

That said, there is also a significant regional dimension to this story, as was highlighted by Figure 6.7 in Section 6.2. The proportion of the working-age population in the ESA support group varies from under 3% in some parts of the South West of England, to over 5% in some parts of the North West of England, the South of Wales, and Clydeside in Scotland. This means first that there will be very differential impacts in terms of the number of people affected across the country by any policy change of this kind; and second that there are likely to be particularly significant extra resources required in Jobcentres concentrated in certain parts of the country. Any policy change should be made bearing in mind the resources required to deliver it effectively, and the geographic dimension to that.

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<sup>34</sup> Source: Department for Work and Pensions, 'Jobseeker's allowance and employment and support allowance sanctions: decisions made to June 2016', November 2016, <https://www.gov.uk/government/statistics/jobseekers-allowance-and-employment-and-support-allowance-sanctions-decisions-made-to-june-2016>.

We now turn attention to the characteristics of the claimants who could be affected by the Green Paper proposals, and what types of challenges these suggest work coaches may face were they afforded more discretion. We look first at survey data on incapacity benefits claimants from the English Longitudinal Study of Ageing (ELSA). ELSA is a large-scale survey of individuals in England aged 50 and over, which has interviewed respondents biennially from 2002–03 onwards and is intended to be representative of English households. ELSA includes information about survey respondents' health conditions, any mobility or capability issues, a range of self-reported health measures, and measures related to depression, as well as a wide range of information on other characteristics. These data only allow us to look at the subset of claimants aged 50 years and over in England and, due to sample size, we do not separately analyse individuals in the ESA support group. But this age group accounts for about half of ESA claimants, and two-thirds of ESA claimants aged 50 and over are in the support group.<sup>35</sup>

**Table 6.1. Characteristics of people aged between 50 and the state pension age, by incapacity benefits receipt**

	Receiving incapacity benefits (8%)	Not receiving incapacity benefits (92%)	All (100%)
Female	35%	43%	42%
Low educated	63%	40%	42%
Mid educated	32%	38%	37%
High educated	5%	23%	21%
Married or cohabiting	57%	81%	78%
Has working partner (of those with partner)	42%	72%	70%
<b>Health characteristics</b>			
0–2 health problems	29%	88%	83%
3–5 health problems	34%	10%	12%
6 or more health problems	37%	3%	6%
Hearing problems	29%	15%	16%
Eyesight problems	24%	9%	11%
Incontinence	20%	9%	10%
Depressive symptoms	40%	9%	12%
Any mobility problems	89%	37%	41%

Note: Health 'problems' are 12 binary indicators covering mobility, eyesight, hearing, incontinence, stress and depression.

Source: Authors' calculations using ELSA data, waves 1–7. Sample of 28,286 individuals.

<sup>35</sup> Source: figures for May 2016 from the DWP tabulation tool ([http://tabulation-tool.dwp.gov.uk/100pc/esa/age/esa\\_phase/a\\_carate\\_r\\_age\\_c\\_esa\\_phase\\_may16.html](http://tabulation-tool.dwp.gov.uk/100pc/esa/age/esa_phase/a_carate_r_age_c_esa_phase_may16.html)).

We start by looking at differences in general (i.e. non-health) characteristics between incapacity benefits recipients and non-recipients aged 50 and over. Table 6.1 shows that, as we saw for working-age adults as a whole in Section 6.2, incapacity benefits claimants are relatively likely to be male and low educated. This is important: those with low levels of formal education are likely to have lower levels of skills more generally, and this will form another potential barrier to work faced by this group. We also see that claimants are less likely to be married than non-claimants and, of those with a partner, their partner is much more likely to be out of work.

To examine the health status of incapacity benefits claimants in ELSA, we use data on 12 self-reported health conditions relevant to incapacity benefits claimant status, covering mobility, eyesight and hearing problems, incontinence and depressive symptoms.<sup>36</sup> The health panel of Table 6.1 shows that over 70% of incapacity benefits claimants have three or more health conditions on this measure, compared with just 12% of non-claimants. Over one-third of claimants have six or more health conditions. At the other end of the scale, among those not receiving incapacity benefits, 88% report between zero and two health problems, while this is true of 29% of those receiving incapacity benefits.

The prevalence of incapacity benefits claimants with multiple health conditions could strengthen the case for providing work coaches with more discretion as they may be able to take into account the barriers to work that could be caused by the plethora of different combinations of problems. But it might also suggest that significantly reducing the disability employment gap by getting many more of these individuals into paid work will not be a straightforward task.

Unsurprisingly, a higher proportion of claimants of incapacity benefits have health conditions that could inhibit their ability to work than do non-claimants. However, the extent to which health conditions are concentrated among incapacity benefits claimants differs by condition. The concentration is particularly marked for those with depressive symptoms: these conditions are four times more prevalent among incapacity benefits claimants than among non-claimants. The prevalence of mental and behavioural issues more generally is an important issue here, to which we return below.

So far, we have discussed the average characteristics of those receiving incapacity benefits. What may matter more for the objective of getting more of these individuals into paid work is the characteristics of those with the least severe health problems, who we might expect work coaches to engage with more intensely if they are afforded more discretion, as the Green Paper advocates. We are limited by the available data in how we can examine this, but what we can do is to categorise claimants according to the *number* of conditions they have.

Table 6.2 splits incapacity claimants into three roughly equally sized groups, according to their number of reported health conditions. We report the average of various characteristics for each of these groups. The claimants with fewest health conditions (0–2 health conditions), and who may therefore be relatively likely candidates for greater work-coach engagement, are significantly more likely to be male and to be single than those

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<sup>36</sup> These are the conditions used to construct the health index in J. Banks, R. Blundell and C. Emmerson, 'Disability benefit receipt and reform: reconciling trends in the United Kingdom', *Journal of Economic Perspectives*, 2015, 29(2), 173–90.

with many health conditions. They are also more highly educated than claimants with more health problems – but still considerably less educated than the population as a whole (55% were not educated beyond compulsory school-leaving age, compared with 41% among all adults between 50 and the state pension age). Hence their potential labour market opportunities, all else equal, may indeed be somewhat better than those of the claimants with more health problems – reinforcing the case for focusing more attention on this group than on other claimants as part of efforts to increase employment. But they are still a relatively low-educated group, so getting a large fraction of them into stable employment will still be difficult.

Education levels aside, the increased prevalence of mental and behavioural conditions is perhaps the most important factor for the government to respond to effectively, if efforts to move more incapacity benefits claimants into work are to be successful. We have seen for those aged 50 to the state pension age that the relative likelihood of such claimants having depressive symptoms is high. Broadening the analysis to all working-age individuals using administrative data, Figure 6.10 shows that half of incapacity benefits claimants now have a mental or behavioural disorder as their primary health condition at the point they start claiming – up from less than one-third at the turn of the century. Among these, the most common problems were depression, stress and anxiety. Previous research has shown that the proportion of claims attributed to mental and behavioural disorders has increased for all age groups and for both men and women, with growth strongest among young men.<sup>37</sup> A mental and behavioural disorder rate of around one-half applies in both the ESA WRA and ESA support groups.<sup>38</sup>

**Table 6.2. Average characteristics of incapacity benefits recipients aged 50 to state pension age, by health status**

	0–2 health problems	3–5 health problems	6+ health problems	All recipients
Female	28%	36%	41%	35%
Low educated	55%	65%	63%	61%
Mid educated	34%	27%	31%	31%
High educated	8%	5%	3%	5%
Married or cohabiting	52%	58%	59%	57%
Has working partner (of those with partner)	46%	47%	35%	42%

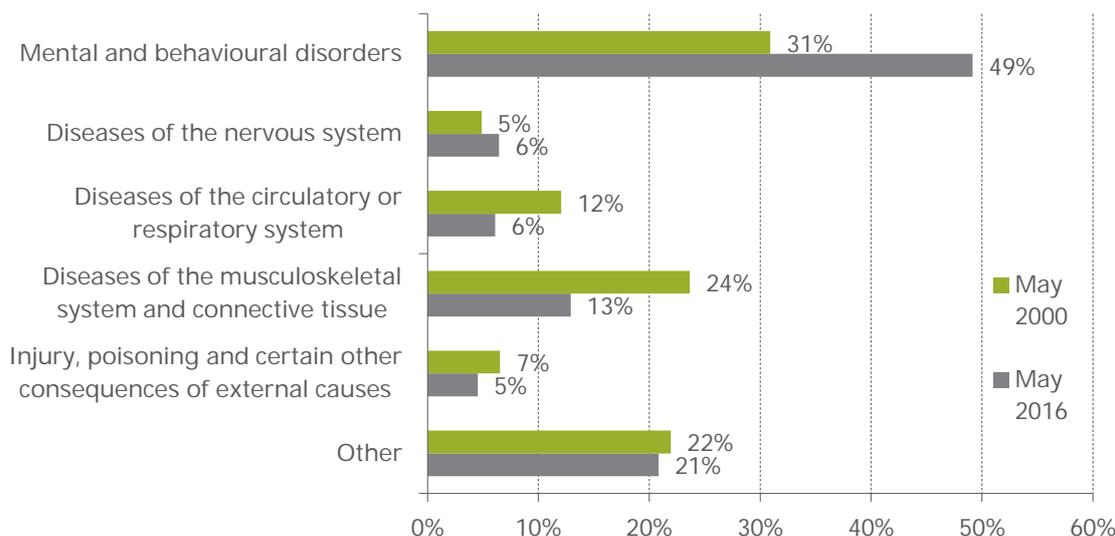
Note: Health ‘problems’ are 12 binary indicators covering mobility, eyesight, hearing, incontinence, stress and depression.

Source: Authors’ calculations using ELSA data, waves 1–7. Sample of 2,333 ESA or IB recipients.

<sup>37</sup> J. Banks, R. Blundell and C. Emmerson, ‘Disability benefit receipt and reform: reconciling trends in the United Kingdom’, *Journal of Economic Perspectives*, 2015, 29(2), 173–90.

<sup>38</sup> [http://tabulation-tool.dwp.gov.uk/100pc/esa/icdgpsumm/esa\\_phase/a\\_carate\\_r\\_icdgpsumm\\_c\\_esa\\_phase\\_may16.html](http://tabulation-tool.dwp.gov.uk/100pc/esa/icdgpsumm/esa_phase/a_carate_r_icdgpsumm_c_esa_phase_may16.html).

**Figure 6.10. Percentage of working-age incapacity benefits claims due to different health conditions**



Source: Authors' calculations using Department for Work and Pensions tabulation tool ([http://tabulation-tool.dwp.gov.uk/100pc/esa/tabtool\\_esa.html](http://tabulation-tool.dwp.gov.uk/100pc/esa/tabtool_esa.html)). Conditions are classified according to the International Classification of Diseases.

The 2014 Adult Psychiatric Morbidity Survey (APMS) found an even higher rate (64%) of mental health conditions among those on ESA.<sup>39</sup> This is compatible with the DWP data in Figure 6.10, as recipients often have multiple health conditions (as shown in Table 6.1) and may develop mental health conditions after they move onto benefits, which could be picked up in the APMS but would not be recorded in the administrative data. In contrast, the APMS found that the rate of mental health conditions was much lower among those in paid work (14.4% among those in full-time employment and 16.5% among those in part-time employment).<sup>40</sup>

The high, and increasing, prevalence of mental and behavioural disorders among those receiving incapacity benefits is not unique to the UK. An OECD report from 2009<sup>41</sup> found that 'Mental and psychological problems represent around one-third of disability benefit inflows on average in OECD countries. This share has shown a massive increase in many countries for which data are available over the past decade. For instance, in Switzerland and Denmark the share of mental problems in disability inflows has grown from 25% to over 40%, and from 15% to 40% in Sweden'.

All this suggests that it is likely to be very important how well equipped work coaches are to deal with the nature of mental and behavioural disorders – including, for example, their tendency to fluctuate and the possibility that, in some cases, an imposition of potentially unwanted regular interactions with the threat of sanctions (perceived or real) could have adverse effects for the claimant's health.

<sup>39</sup> Mental health conditions include depression, postnatal depression, obsessive compulsive disorder, panic attacks, other anxiety conditions and other conditions.

<sup>40</sup> See tables 2.9 and 2.10 in <http://content.digital.nhs.uk/catalogue/PUB21748/apms-2014-full-rpt.pdf>.

<sup>41</sup> See page 214 – and figure 4.3 on page 217 – in chapter 4 of OECD, *Economic Outlook 2009*, <https://www.oecd.org/els/emp/45219540.pdf>.

## 6.5 Conclusion

In 2016–17, the government is forecast to spend £24.4 billion on disability and incapacity benefits that are received by 3.5 million working-age people. In terms of incapacity benefits, some key trends are that:

- spending on working-age incapacity benefits as a percentage of national income is currently at its lowest level since 1989–90 and is forecast to reach its lowest level for over 40 years by the end of this parliament;
- over the last three decades, the generosity of incapacity benefits payments has fallen as a share of average earnings: in 1986–87 the average award was 24% of male full-time average earnings, whereas by 2016–17 this had reached 19%;
- incapacity benefits have increasingly gone to those with low levels of education, and less to older men, and it is now the case that mental and behavioural disorders are the principal cause of half of ESA claims.

This is a difficult area of policy. The government is trying to provide financial support to some of the most vulnerable people in society, whilst ensuring that those who are able to do paid work have sufficient incentives to do so, and that the benefits system sets reasonable expectations (in terms of work-related activity) for those whose health is – or has some prospect of – improving. It is an important area to get right, for the country as a whole as well as for those unfortunate enough to be in ill health: we are spending more than 1% of our national income on incapacity and disability benefits for individuals of working age. It clearly matters whether this money is providing the right financial support to the right set of people, and whether the support is conditional on the right kinds of requirements.

Recent reforms to these benefits have encountered significant difficulties, not least in terms of predicting their effects. Governments have been guilty of repeated over-optimism when predicting how many people will be assessed by new tests as not needing assistance with daily activities or mobility, or as being fit to work, or as being fit to undertake work-related activity. Hence there has been consistent over-optimism about the impacts of reforms on the public finances.

The one confirmed change in the pipeline is a cut to the rate of support for the ESA WRA group, which will be phased in gradually through its application to new claimants from April 2017. As a cut to the rate of support, rather than a change to health assessments, its primary impacts are easier to anticipate. Ultimately, it will mean that about 450,000 people will receive about £30 per week less than they would have done (and will receive the same as JSA claimants).

But in terms of potential further policy measures, the government's focus is now somewhat different from what we have seen in the recent past. It is not directly looking at reducing spending on these benefits, but it wants to reform incapacity benefits in a way that helps to meet its commitment to halve the disability employment gap (though, of course, successful pursuit of this objective would be likely to reduce benefit spending and to boost tax revenues). As part of this approach, the government suggests a renewed focus on the ESA support group, most of whom are not currently doing any work-related

activity and who have (in sharp contrast to the original expectation) ended up as the majority group of ESA claimants.

Providing greater discretion to Jobcentre work coaches to tailor the level and type of engagement with support group claimants to individual circumstances (as the Green Paper proposes) may well be a sensible direction for reform. As ever though, discretion brings with it risks as well as potential upsides.

In the face of diverse and complex health conditions, will work coaches be sufficiently equipped to take on greater flexibility while ensuring consistency and fairness of assessments across claimants, not least across those in different parts of the country? The rapid rise in the prevalence of mental and behavioural health conditions among ESA claimants, and the ability of work coaches to handle people with those potentially fluctuating conditions appropriately, will present a particular challenge.

We have also shown that those receiving incapacity benefits are a relatively low-educated group of people – and that this is true to a much greater extent than in the past. The disability employment gap is largest amongst the low-educated. So making large inroads into that gap will require a substantial increase in the labour market attachment of a low-skilled group.

One thing that seems certain is that, if any substantial change is to be brought about, the sizeable increase in engagement with the 1.5 million individuals in the ESA support group is going to require a significant amount of additional resource. This group is 50% larger than the group of ESA WRA group claimants and JSA claimants who are already engaged in work-related activity.

Given the obvious gaps in our knowledge about how best to engage these kinds of people in work-related activity, and the significant amount of public money that would be needed to increase engagement with them on the scale being considered, this area looks like a strong candidate for the use of some trials to learn more about what works best (both in terms of employment, incomes and public spending and in terms of the claimants' health and general experience). In addition, careful consideration will need to be given to whether greater engagement with work coaches – and, if so, how much engagement – should be made compulsory, with possible sanctions for those who do not comply, or whether there are better ways to bring about the outcomes that the government is seeking. For example, a 'middle way' could involve a presumption that the support group (excluding those with particularly severe or terminal conditions) will partake in some work-related activity, but with a clear opportunity for them to opt out.